APPEAL NO. 020809
FILED MAY 13, 2002

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on March 14, 2002. With regard to the only issue before him, the hearing officer determined that the appellant's (claimant) impairment rating (IR) is 14%.

The claimant appeals, contending that the correct IR is the 15% as assigned by the designated doctor. The respondent (carrier) responds, urging affirmance.

DECISION

Reversed and remanded.

The parties stipulated that the claimant sustained a compensable (cervical spine) injury on _____, and that the claimant reached maximum medical improvement (MMI) on May 8, 2001. The medical records indicate that the claimant, a flight attendant, sustained a cervical injury during a "hard landing." The claimant received medical care and eventually began treating with Dr. A, a chiropractor, who the parties stipulated was the treating doctor. The parties also stipulated that Dr. A certified MMI on March 21, 2001, with a 0% IR.

The claimant disputed Dr. A's assessment, and Dr. RS, a chiropractor, was appointed as the designated doctor. Dr. RS, in a report dated May 8, 2001, certified MMI and assessed a 15% IR, based on a 6% impairment from Table 49 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) and a 10% impairment for loss of range of motion (ROM), combined to result in the 15% IR. Although Dr. RS did not specifically identify Section (II)(C) of Table 49, he commented that the claimant "suffered an intervertebral disc lesion . . . with medically documented injury, pain and rigidity associated with *moderate to severe* degenerative changes on structural tests. This could include unoperated on herniated nucleus puplosus [HNP] with or without radiculopathy." (Emphasis in the original.) (Language similar to the description under Section (II)(C) of Table 49.) The carrier disputed that rating and requested the Texas Workers' Compensation Commission (Commission) forward a letter of clarification.

The Commission simply forwarded the carrier's request for clarification (actually a critique of Dr. RS's report) to the designated doctor. Dr. RS responded, but in doing so, transposed the figures in his rating to show a 10% impairment from Table 49 and a 6% impairment for loss of ROM. Apparently, most of a benefit review conference (BRC) was taken up with the benefit review officer (BRO) contacting the doctor and, in a speaker phone conference, correcting the transposed numbers. Dr. RS affirmed his 6% impairment for a specific disorder and 10% impairment for loss of ROM. At the BRC, it appears that

it was agreed that the claimant would be examined by a Commission-required medical examination doctor, Dr. HS.

Dr. HS, in a report dated November 15, 2001, certified MMI and assessed an 8% IR based on 4% impairment from Table 49, Section (II)(B) and 4% for loss of ROM.

Although there was some dispute about the ROM figures at the CCH, the hearing officer resolved that matter in the claimant's favor, finding that the claimant's impairment for ROM deficits was 10%, and that finding is unappealed.

At issue is whether the claimant should be rated under Section (II)(B) or Section (II)(C) of Table 49. Although that matter was raised in the letter for clarification that the BRO forwarded to Dr. RS, the matter of the transposed figures took the foreground. In his reply on August 2, 2001, Dr. RS stated:

> [The claimant] has suffered a soft tissue lesion which presents as unoperated on, stable, with medically documented injury, pain and rigidity associated with none to minimal degenerative changes on structural tests, such as those involving roentgenography or magnetic resonance imaging.

We note that this is slightly, but perhaps importantly, different than the comment that Dr. RS made in his original report as cited previously.

Table 49, Section (II)(B) allows a 4% impairment for:

> B. Unoperated with medically documented injury and a minimum of six months of medically documented pain, recurrent muscle spasm or rigidity associated with none-to-minimal degenerative changes on structural tests. [Emphasis added.]

Whereas Section (II)(C) allows a 6% impairment for:

> C. Unoperated with medically documented injury and a minimum of six months of medically documented pain, recurrent muscle spasm, or rigidity associated with moderate to severe degenerative changes on structural tests, including unoperated [HNP], with or without radiculopathy. [Emphasis added.]

The carrier also argues that there is no evidence that the claimant has an HNP and therefore Section (II)(B) is the proper section to rate the claimant.

The hearing officer quotes both Section (II)(B) and (II)(C) of Table 49, notes Dr. RS's clarification response, and concludes that Dr. RS

> in his justification, states the Claimant has undergone none to minimal degenerative changes. A proper interpretation of the [AMA Guides] would place this condition under Table 49, II – B, with the concomitant [IR] of 4%.

The hearing officer erred in so concluding. Whether a claimant is rated under Section (II)(B) or (II)(C) of Table 49 is a matter of medical judgment to be left to the doctor. Further, the hearing officer completely ignores the narrative in Dr. RS's original report, which would tend to support the rating under Section (II)(C). Instead, the hearing officer uses the "clarification" letter which might already be suspect because of the error involving transposed numbers.

We remand the case for the hearing officer to request specific clarification from the designated doctor as to why he believes Section (II)(C) should be used rather than Section (II)(B), and whether the claimant has "*moderate to severe* degenerative changes" as stated in his original May 8, 2001, report or whether the changes are "none to minimal" as noted in his August 2, 2001, response letter. The designated doctor is also to be asked what, if any, evidence exists of an HNP and/or radiculopathy. The designated doctor may reexamine the claimant if deemed necessary. The designated doctor's response is to be made available to both parties and both parties will be allowed to provide oral and/or written responses. No additional evidentiary hearing, other than Dr. RS's response, is necessary. The hearing officer will prepare a new Decision and Order either adopting the designated doctor's report or, finding that the great weight of the other medical evidence is contrary to the designated doctor's report, adopt the report of either Dr. HS or Dr. A.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Commission's Division of Hearings, pursuant to Section 410.202 (amended June 17, 2001). *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **PACIFIC EMPLOYERS INSURANCE COMPANY** and the name and address of its registered agent for service of process is

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Thomas A. Knapp
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Roy L. Warren
Appeals Judge